Aerosol Transmissible Disease
Cal/OSHA Advisory Meeting – Draft Minutes
Law Enforcement and Corrections
May 31, 2006 Oakland CA

Chairs: Robert Nakamura, Deborah Gold

Participants

Patti Bennett, Sonoma County Sheriff
Charles Boettger, Municipal Police Authority
Charity Camaddo-Nicolas, Contra Costa County
John Campbell, California Department of Corrections and Rehabilitation
Amy Christey, Santa Cruz County Sheriff's Office
Kevin Connor, San Bernardino County Sheriff
Barbara Cotton, The Cotton Group/Forensic Medical Group
Jeff Fairbanks, Stanislaus County Sheriff's Office
Paul Fernandez, Napa County Department of Corrections
Heidi Fowers, Sonoma County Risk Management
Teresa Fricke, San Bernardino County Sheriff
John Gluckert, Ventura County Sheriff
Suzi Goldmacher, California Department of Health Services
Al Guzman, Contra Costa Sheriff's Department
Denny Hutton, Sonoma County Risk Management
Beth Kilian, Contra Cost County Office of the Sheriff
John Lincoln, County of Lake
R. North, Sonoma County Sheriff's Department
David Pascoe, Contra Costa County Sheriff's Office
Tim Pearce, County of Mendocino
Frank Perriello, San Bernardino County Sheriff's Department.
Zohreh Pierow, County of Santa Clara
Margaret Porter, Santa Cruz Sheriff's Office
Bob Pruitt, San Bernardino County Sheriff's Department
Sharlene Ramey, Fresno County Sheriff's Department
Scott Rivers, Sonoma County Sheriff
Darryl Smith, Ventura County Sheriff
Vickie Wells, San Francisco Department. of Public Health
Adam Wolfe, California Department of Corrections and Rehabilitation

Summary of Key Points

1. There was discussion about appropriate measures for protecting employees who provide non-medical transport to suspect or confirmed cases being referred to other facilities (such as hospitals) as possibly requiring airborne infection isolation. In addition to source control measures (such as masking) for the patient, or use of respirators by employees, the participants discussed the results of an

experiment in which smoke tubes were used to characterize air flow from the passenger compartment of a patrol car with a solid partition.

2. Participants wanted the standard to make clear which vaccinations are required to be provided to which law enforcement and corrections personnel. Several participants reported that their agency provided some vaccinations to some employees. Most participants supported requiring the provision of seasonal flu vaccine to health care personnel within law enforcement and corrections, but there was disagreement about extending that requirement to all law enforcement and corrections personnel.

3. Participants generally supported having a summary sheet such as the one handed out at the meeting, which lists the requirements that would be applicable to referring employers in law enforcement and corrections.

Detailed Minutes

Below are detailed notes of the advisory meeting. These notes do not represent a transcript of the meeting, and are simply a summary of the notes taken by the people conducting the meeting. Although every effort has been made to accurately reflect the opinions expressed in the meeting, they should not be considered to be a verbatim record of the proceeding.

Deborah Gold opened the meeting and reviewed the history of the project. She thanked the attendees for participating today and noted that some people had returned from previous meetings, which is especially helpful in developing the proposal. She said that this is the tenth advisory meeting for the Aerosol Transmissible Diseases (ATD) standard and is intended to focus on law enforcement and corrections settings. She explained the rulemaking process, and said that the Division (Division of Occupational Safety and Health, Cal/OSHA) expected to send a proposal to the Occupational Safety and Health Standards Board (Standards Board) in June, where it will be reviewed by the staff for several months prior to publication for a 45 day public comment period, at the end of which the Standards Board will hold a public hearing. If there are changes that need to be made, there will be one or more 15 day notices, and then eventually the Standards Board will vote on the proposal. The participants were then asked to identify themselves.

D. Gold then reviewed the categories of diseases that are covered by the proposal. She explained that there are 7 or 8 diseases that are listed by the CDC and DHS as airborne diseases which include tuberculosis (TB), SARS (Severe Acute Respiratory Syndrome), monkey pox, smallpox, measles, and varicella, which includes chicken pox. In this proposal, novel avian influenza strains like H5N1 which can cause disease in people would also be considered as airborne. Many other diseases are considered to be transmitted by droplets, such as mumps, diphtheria, and pertussis. She explained that the infection control and industrial hygiene professions look at the issue of droplet transmission differently, because some of the “droplet” diseases may also be transmitted by small particle aerosols that are inhalable and cause infection. This is how the standard

came to be named the Aerosol Transmissible Disease standard, because it addresses both categories of diseases, but only requires higher level controls like negative pressure rooms for diseases classified as "airborne."

The proposal is structured to include in the scope those work environments, like jails, in which employees are at elevated risk of exposure to individuals who are infectious with an ATD, in circumstances in which the risk of transmission is increased. Many jails and detention facilities do not have any isolation rooms or facilities to properly isolate people with one of the airborne diseases. So the proposal divides facilities between those that provide services to people requiring airborne infection isolation, and those facilities that will transport or otherwise refer those patients to a hospital or other facility who can provide airborne infection isolation.

Transport and Referral

D. Gold explained that in those facilities that don't provide airborne infection isolation, which are called "referring employers" in the standard, one of the main points of exposure particularly for law enforcement and corrections is during transport. There was discussion at last year's meeting of equipping vehicles with control measures to reduce the exposure as an alternative to the driver wearing a respirator. Many concerns were raised at that time. The San Francisco Department. of Health investigated this concept with their own vehicles that are equipped with a plastic barrier between the area where a detainee would be kept, such as the rear seat, and the front seats. D. Gold asked Vickie Wells to describe the experiment.

V. Wells said that she worked with the San Francisco Sheriff's Department to test a four-door sedan with a plastic barrier by using non-irritant smoke tubes to see how the air moved in the vehicle and if there was a significant movement of air from the back seat to the front. They also looked at a vehicle with a metal mesh barrier. They found that with the metal mesh barrier, under some circumstances smoke traveled into the front seat. With the solid plastic barrier, they found that the smoke did not go into the front seat except for small eddy currents if the smoke was shot directly at the edges of the barrier. The smoke tended to move into the trunk of the car. Bob Pruitt asked if the barrier had to go all the way across the seat. D. Gold said that the standard would require that either the source patient be masked or the employees would use respirators. The exception proposed would provide a third option, if the employer can demonstrate that there is no detectable travel of contaminants between the passenger compartment and the area where the employees are seated. It is intended to be performance based. B. Pruitt asked if this would be part of the standard for transporting medical cases. They sometimes have to transport people from remote parts of the county for up to three hours. D. Gold responded that it would only apply to non-medical transport, and that medical transport would have to be done by qualified people. John Lincoln asked V. Wells if the tested car was parked or being driven, and whether the windows were cracked. V. Wells said that the testing was performed with the vehicle parked and driven in a large lot, but it was not done with the windows cracked. J. Lincoln noted that Lake County facilities won't take an inmate arrested for violent crimes. Barbara Cotton asked how this would mesh with federal

OSHA and the CDC. The CDC says that an officer will wear respirators while driving a suspect case. D. Gold replied that an employer can always provide additional protection to that required by a Cal/OSHA standard. She said that federal OSHA doesn't have a specific standard on this and the CDC document is a guidance document, not a regulation. Currently, Cal/OSHA uses the CDC guidance as the basis for identifying appropriate actions on the part of employers as part of injury and illness prevention programs required under section 3203, but the guidelines alone do not have the force of regulations. The idea of this exception is to allow an employer to demonstrate that the employee is not in fact in the same breathing space as the suspect case, and to use this method to reduce the risk of exposure as an alternative to using respirators. Kevin Connor said that he was concerned about not using a respirator because they may have to take the detainee out of the back seat, and the person may be combative. Also, he is concerned about the next occupant of the vehicle.

Tim Pearce asked for clarification on who is considered a suspect case, and whether that includes a positive PPD (purified protein derivative, sometimes referred to as the tuberculin skin test). D. Gold responded that a person would be considered a suspect case based on observable signs and symptoms, and history, and that many people have a positive PPD without having active disease. She said that departments have different procedures for handling suspect TB cases based on the way the facilities are equipped and where they take the inmates for treatment, etc. Not all departments have solid barriers in the cars. Denny Hutton noted that it might be easier to put 3 masks in each patrol car. D. Gold said that was one solution but it would also require all of the officers to be fit-tested. B. Pruitt asked if that would mean annual medical evaluations also, but was told only an initial medical evaluation is required by the standard. He asked if Cal/OSHA had created an exemption for police officers from the medical evaluation requirement. D. Gold explained that the Cal/OSHA medical unit, at the request of the acting chief, had evaluated the current POST (Police Officer Standards and Training) physical, and determined that it is equivalent for standard duty police officers, to the Section 5144 (respiratory protection standard) questionnaire. Section 5144 requires an additional evaluation only under certain circumstances, such as if the doctor decides it is necessary, the employer notices obvious facial or other changes in the employee, or the employee reports difficulty with using the respirator. However, she said that it isn't good practice for employer's to rely on a 10 or 20 year old physical, and that the employer can build a re-evaluation into their respiratory protection program.

K. Connor noted that the partition in the car can cause air stagnation that would build up aerosols that might infect personnel who are cleaning the cars, or the next occupant. V. Wells noted that in her experiment, the smoke did not build up in the passenger area, but moved into the trunk. K. Connor said that officers need to open the trunk, for example they store their guns there when they go into jails or certain buildings. D. Gold said that there is a requirement for decontamination, and that the risk of exposure to subsequent passengers would depend on the specific disease. B. Cotton said that the standard should incorporate universal precautions, and that officers should protect themselves if they're in the back of the vehicle. D. Gold said that the source control provisions were intended to be a type of universal precautions. The exception was developed because there has been a

lot of resistance to having employees wear N95s. D. Hutton asked if it would be better to install a permanent barrier between the front and back seats.

Charity Camaddo-Nicolas noted that she liked some of the changes from previous versions of the proposal, and that some of the new options are good. However she had three concerns. First, the cost of respirators, even N95s for the drivers and masks for passengers, secondly the implementation of the programs would be difficult, and third the requirement for vaccination requires the local agency to defend against occurrence as a liability issue, for example, the smallpox vaccination. D. Gold said that Title 15 already requires that corrections have infection control procedures. She said that although smallpox is an ATD, there is no recommendation from the CDC to vaccinate law enforcement. The CDC has made recommendations for vaccinations of specific groups of workers for a few diseases; the vaccination recommendations are not for all employees. She and B. Nakamura have met with the Immunization Branch of the Department of Health Services (DHS) to review the CDC recommendations, and they will be included in the proposal. She said there would likely also be a guidance document to go with the regulation, or an appendix to clarify the recommendations. If there were an exposure incident, then additional vaccines might be recommended as part of the post-exposure follow-up. C. Camaddo-Nicolas responded that if the regulation is vague, it leaves them open to liability, for example if an officer gets smallpox. D. Gold said that pertussis vaccine, for example, is not recommended by the CDC for correctional employees, but it is recommended for health care workers, so that would be incorporated into the proposal.

D. Gold asked to see hands of people in organizations that currently have some type of vaccination program. John Lincoln (Lake County), B. Cotton (Health Services Management Group), Al Guzman (Contra Costa County), Dave Pascoe (Contra Costa County) and Amy Christey (Santa Cruz) raised their hands. B Cotton said that there are two groups of workers in a jail, the health care staff and the corrections staff. The health care workers mostly comply with CDC guidelines, but not all of the custody staff do. D. Gold asked how many departments provide airborne infection isolation for detainees, and how many send the people to hospitals. Eight participants said they kept people in the jails, and San Francisco and Contra Costa said they sent them to hospitals. D. Gold said that the goal of this proposal is to build on the existing communicable disease control plans.

Jeff Fairbanks asked what the difference was between a mask and a respirator. D. Gold said that a respirator is approved by NIOSH to protect the user from inhaling contaminants, and surgical masks are not approved for this purpose. Surgical masks are meant to reduce exhaled material from an individual to reduce the potential exposure to other people. Surgical masks are not tight-fitting respirators and are not fit-tested, so they can't be relied on to protect the user. N95's are supposed to reduce the exposure inside the respirator to 1/10 or less of the exposure outside the respirator. Al Guzman asked if the N95 is appropriate for transport, or if they should go to a higher level. B. Cotton said that NIOSH says that the N95 is appropriate, except for high hazard procedures. Unless a person has a particular susceptibility, there's no need for higher levels of protection. A Guzman asked if it was true that the experience with SARS in Canada showed that the

use of N95's isn't effective. D. Gold said that the procedures in question were high hazard procedures. She said that the advantage of N95's is that they are disposable. The disadvantage is they might not maintain the facepiece seal as well as an elastomeric facepiece. Even though you are fit-tested, when you put on a disposable respirator, you make a different seal each time. Most high risk procedures are performed in a medical setting, by medical personnel, so this would not affect law enforcement officers. A. Guzman asked if she thought N95s were sufficient. D. Gold responded that Cal/OSHA wouldn't have a problem with departments who wanted to use a higher level of protection. She said that in general, the provisions of the standard do not eliminate risk, they are an attempt to reduce it.

D. Gold asked the group about what happens when they extract someone from the rear seat of the patrol car. Dave Pascoe asked how long it should take for the air to change out after occupancy if both doors are left open. V. Wells said that she would be more concerned about the face-to-face contact while doing the extraction. She said that when the doors were opened, the smoke cleared quickly, but she didn't time it. She said the smoke also cleared quickly from the trunk when it was opened, but she wasn't sure that all aerosols would behave the same as the smoke. Their sheriffs didn't raise the issue of extracting the person from the car. D. Pascoe said that he would have to look at how often they have to remove a person from the car, and how many of those people are infected. He said that if they had to ventilate the car for a couple of minutes, that wouldn't be a problem. Also, if you could open both side doors, that might help.

B. Pruitt asked if this meant that all deputies who do transfer and extraction would have to wear respirators, even for a brief exposure. D. Gold said that the standard is not structured like the bloodborne pathogens (BBP) standard, in that BBP applies in all situations with occupational exposure. BBP has been applied in the adult film industry, to the use of tagging guns in retail, as well as to law enforcement and healthcare. This standard would apply to high risk occupations and environments. It wouldn't apply to all public contact groups, such as bus drivers, school teachers, or DMV clerks. The experts who wrote the CDC TB guidelines could not determine a safe duration of exposure. Sometimes TB is transmitted with fairly brief exposures, in part because it depends on the nature of the exposure and the infectivity of the patient. Therefore, she doesn't know if a brief exposure while removing someone from the back of the car is enough to transmit TB. Ten minute exposures to high hazard procedures have resulted in transmission, but there isn't documentation of transmission from this kind of contact. The standard will not eliminate all risks, since that would make it impossible to do the job. The standard is meant to reduce risks. Casual exposures are not included in this standard, and in that way it is similar to the CDC TB guidelines.

V. Wells said that in SF, a suspect case is first evaluated before being sent to court. B. Cotton said that in some counties they do take the people to court before confirmatory testing is done. J. Lincoln said that in their county they had no isolation cell until they had an inmate with TB. They had heightened concern for several weeks, but there were no other cases. They have a program for precautions but it is hard to get patrol officers to take it seriously. John Campbell said that they have mandatory testing of inmates at

reception, and annual TB tests of employees and inmates. They have over 100 medical employees, and they have isolation rooms. If there is a TB case, there is a lockdown procedure. The buses already have plastic barriers. All of their transport staff are already fit-tested. His concern is vaccination requirements – they have 60,000 employees in the California Department of Corrections and Rehabilitation (CDCR).

A. Guzman asked if they are considered to be presumptive injury cases in workers compensation, like heart attacks are. J. Campbell said that SCIF (the State Compensation Insurance Fund) has to determine that. Darryl Smith asked if there was any quantification of law enforcement cases. D. Gold said there were active cases in jails leading to Cal/OSHA involvement. CDC statistics show that prison guards are at increased risk, and there have been documented clusters of conversions in prisons. She said that if a department's communicable disease plan is working well, this standard will probably have little additional effect, except in requiring medical surveillance and communication. Departments who are providing respirators should be complying with Cal/OSHA's respiratory protection standard. D. Smith said that their department has had 2 TB cases in 26 years. He said that their problem is that they are using SCBAs and Millenium masks (a full-facepiece respirator). They are now doing medicals and fit-testing on 3 different masks that they may never use. D. Gold said that in terms of medical evaluations, the medical provider who evaluated employees for use of the other respirators may be able to medically qualify people for using the N95s. She said it is important that employees feel sufficiently protected that they will come to work if there's a public health emergency. If measles was in your jail, you'd probably vaccinate the prison guards. She said that a department with a functional communicable disease control program will find very little new in this proposal, but it should be customized for the risks they face. J. Campbell said that California has not employed a "prison guard" since 1942. The correct term is correctional officer.

Charles Boettger asked if Cal/OSHA Consultation is going to produce a complete guide to the regulation, including information about the vaccines. D. Gold said that a series of focused documents for specific types of work settings is being planned, and that a draft of one for this group has been handed out today. There will either be an appendix or a guidance document regarding vaccines. C. Boettger asked if there would be a model program. D Gold said she didn't know if that would be done or not. She said that the POST respirator program addresses TB, and Cal/OSHA wouldn't want to tread on their toes. A. Guzman said they had given it back to Cal/OSHA. C. Boettger recommended that the Division produce the guidelines before a standard is adopted. D. Gold said that was unlikely, given the time pressures of standard adoption, but they would pass the recommendation along.

Frank Perriello asked why coroners were being included in the standard. D. Gold said the issue had been brought up at the December 8 meeting. She explained that aerosol generating procedures performed during autopsy would come under the main part of the standard. There is a section in the CDC TB guidelines on autopsies, and that is the disease about which the most is known. She asked if his office was following the CDC guidelines. He said that it was, but that he's called a lot of other coroners in the state, and

that outside of LA they hadn't had a TB autopsy case. He said he'd like to see evidence regarding exposures to coroners. D. Gold asked what his department was doing to protect their employees. She asked if they were already taking precautions under the bloodborne pathogens standard to address creation of aerosols. She said that where there has been documented transmission of TB to coroners, the coroners were often not aware that the person had TB.

Regarding precautions and isolation facilities, D. Smith asked what if a small town doesn't have a jail. D. Gold responded that they would be a referring employer. For limited contact, the limited procedures can be incorporated into existing programs. These employers are not in the main part of the standard. But if there is a case, then the procedures for post-exposure follow up would need to be implemented. They would need to have communications procedures, so that they would know of the exposure.

B. Cotton asked, regarding item 10 on the summary sheet, whether the record retention period was the same as in the main portion of the standard, and D. Gold said that it was. D. Smith suggested that the summary sheet should reference the specific subsections of the standard. Teresa Fricke asked whether there was any documentation of increased risk to field law enforcement personnel. D. Gold said she was not aware of any studies that specifically looked at this group as compared to the general group of law enforcement and corrections personnel.

Lunch

Immunizations

V. Wells asked if the proposal would require the seasonal flu vaccine. D. Gold said that the current draft would require it. J. Campbell asked why the flu shot should be provided. It is a waste of tax money when the employee can get it on their own. B. Pruitt said that the city provides the seasonal flu vaccine if the employee wants it, but how would this requirement work given the annual shortages of flu vaccine. V. Wells said that the regulation needs to clarify when the flu shot should not be offered because it is only available seasonally, and to make it available at any time of the year would be extremely costly and often unnecessary. D. Gold said, in answer to the previous question regarding why employers would be required to provide the vaccine, that the reason for the requirement is the increased risk due to occupational exposure, similar to the rationale for requiring Hepatitis B vaccine in the BBP standard. J. Campbell said that the Hepatitis B vaccine can be limited to people with direct contact. With airborne disease you're talking about all of the 60,000 employees in CDCR. All of the support staff in CDCR has occupational exposure because the minimum security inmates may be working in the same areas. D. Gold said that they would have to look at their operation to see if all of these employees have occupational exposure relative to other public contact employees. She said that health care workers are generally assumed to have occupational exposure, but it may not be true for all health care workers. J. Campbell said that the regulation mentions housing, and 75 percent of their employees have housing duties. If there were a flu epidemic, prisoners would be confined to quarters and employees would go to them.

He asked if the recommendation is triggered because of the high density population. D. Gold said that there are two thresholds, the first is the high risk environment and the second is the occupational exposure of the individual employees. D. Smith said that the impact of providing flu vaccine is much greater because it is annual, as compared to Hepatitis B vaccine, which is given once. V. Wells asked for an example of a correctional setting in which employees have occupational exposure. D. Gold responded that health care workers, employees in the infirmary or who handle sick-call, are clear examples. Beyond that, she said she wasn't sure where they should draw the line. She said that the estimates are that flu vaccine costs about $10 per dose, including the cost of the person's time providing the vaccine.

V. Wells said that the ten working days time frame for the seasonal flu vaccine doesn't make sense if you hire a new employee in June. D. Gold said that the CDC recommendations for flu vaccine are time limited (provide prior to and during flu season). V. Wells said that the recommendation doesn't expire, and D. Gold disagreed. J. Campbell said that there is often limited availability of flu vaccine – last year one prison with 5000 inmates got only 500 doses. D. Gold said that in that case, the CDC recommendation was only to provide the flu vaccine to designated groups. She said that in terms of a newly recommended vaccine, we are discussing lengthening the time period for provision from 10 to 90 days. Paul Fernandez said that he could understand providing the vaccine to inmates, but employees have access from their health insurance. B. Nakamura said that was also true for the hepatitis B vaccine, but the Labor Code requires employers to bear the costs of protective measures. J. Lincoln asked whether certain employees have any more exposure than a grocery worker. John Gluckert said that they have three labor unions, and you won't be able to force them to get the vaccine. Public Health would have to administer the vaccine at night, on overtime. He said that shows how impractical the flu vaccine requirement is. B. Nakamura said that the standard would not make the vaccine mandatory for the employees. A. Guzman said that it seemed mandatory to him. Employees would have to go to the occupational health clinic on overtime. J. Campbell said that it wasn't just the flu, the CDC recommends two or three new vaccines a year. This is a logistical nightmare due to the 24/7 schedule of law enforcement. D. Gold replied that the CDC doesn't recommend new vaccines that frequently, and that there are very few vaccines recommended based on occupational exposure. Other than Hepatitis B for BBP, the CDC recommends only a few vaccines, and they are for health care workers -- mumps measles and rubella (MMR), tetanus, diphtheria and pertussis (Tdap) every ten years, and varicella, in addition to seasonal influenza. A. Guzman said that if an employee can refuse a vaccine, why don't we change the emphasis in the regulation to train and encourage employees to get vaccinated via their own medical plans. D. Gold explained that federal OSHA had interpreted the vaccine provisions in the BBP standard to mean that an employee can only go to their own health care provider if the employer pays 100% of their health plan. Also, the employer needs a record of the vaccination if there is an exposure incident. Suzi Goldmacher said that if there's an exposure incident you have to provide proof via the vaccination record or a blood titer, that you are immune.

B. Pruitt said that in distinguishing between health care workers and other jail employees, you are saying that the employer has to decide which other workers are covered. He is worried that the standard is so vague that an employee would complain and there would be an OSHA inspections. D. Gold asked whether the intake people are health care workers, or other employees. B. Pruitt said that people are screened by regular employees, then they will eventually see a health care worker. V. Wells said that with seasonal flu, it's very difficult to decide who is occupationally exposed. D. Gold asked whether the group would think that limiting the flu vaccine requirement to health care workers would be more do-able. There was general agreement that would be better.

B. Pruitt asked if there were data on a need to protect corrections workers from casual contact. D. Gold said that there is data on TB, but that is very different than the flu. With the flu, it's hard to know where people get exposed. She asked if they asked detainees questions about their health. B. Pruitt said that detainees will deny having any health problem if they think it will prolong their stay. They'll say "no" even if they have walking pneumonia. D. Gold said that with TB, the standard is trying to get employers to address symptomatic patients, which shouldn't rely on the person's health statements. In the current draft, there would have to be reasonable source control measures, and a method to recognize a person needing referral. B. Pruitt said that he is concerned that he is being asked to make sense out of people who are lying, and if they don't guess right, they will get cited. K. Connor said that their procedures are very clear. They take no chances with TB. If they suspect TB, they refer them. D. Gold said that's all the standard is trying to accomplish – to have employers act on reasonable suspicion. We don't expect that the employer will deal successfully in every case. The purpose of the standard would be to identify potentially infectious people early, and deal with them appropriately, so that they don't linger in the jail infecting people. If there is a case, we want the employer to follow-up, and that's the purpose of the medical surveillance. There needs to be preplanned coordination with a hospital or the medical facility, so that you will get a call back if the person you transferred was positive. The goal of the standard is to improve the program, not create Cal/OSHA citations.

B. Cotton asked if there could be guidelines for what is a reasonable exposure. For TB, an exposure has to be pretty long in duration. D. Gold said that articles had documented transmission during medical procedures in short periods of time. She said they had asked Dr. Tony Catanzaro whether there are any definite time/space criteria to rule out transmission of TB. He responded that there were no such guidelines. She added that seasonal influenza is not a reportable disease, and therefore doesn't trigger the requirement for exposure investigation and follow-up.

J. Lincoln said that the public health department is notified about TB. He asked if you suspect that a referred patient has TB, can you report that to the hospital. D. Gold said that appears to be permitted under continuity of care. Under this proposal however, the hospital would report the case back without the patient's name. The lawyers have advised Cal/OSHA staff that there is an exception in HIPAA for legally mandated reporting, and this standard would establish that requirement.

Training

D. Gold asked whether people were currently providing training under their communicable disease programs. Many participants indicated that they were. J. Lincoln asked if he could give the training under the standard. D. Gold said he could, if he is qualified, and able to answer questions about the facility's programs. Train-the-trainer programs are okay. C. Camaddo-Nicolas asked if the employer could use a video and provide a person to answer questions. D. Gold said that would be okay, provided the person is qualified and available to answer questions during the training, so that there can be a meaningful exchange. Alternate training formats that meet those conditions would be okay. V. Wells asked for clarification regarding what is meant by subsection (h)(3)(B) ["Epidemiology and Symptoms. A general explanation of the epidemiology and symptoms of aerosol transmissible diseases, including the signs and symptoms of aerosol transmissible diseases."] She asked whether the employer would have to provide the symptoms for each disease. D. Gold said that the intention was to require training on the signs and symptoms that would be used to determine whether a person needed to be referred for further evaluation or airborne isolation. J. Campbell asked if the language in subsection (h)(1) permits training on overtime, and D. Gold responded that would be okay, so long as the time counted as work time.

Summary Sheet

D. Gold reviewed the reason for having a summary sheet and asked for opinions on the draft provided. A. Guzman said he would also like to see the reference to the section of the standard in the sheet. B. Cotton that it is a good idea. The first question is, are we covered by the standard, the second one is, are we a referring employer? This gives the information up front. Randy North said the summary sheet is a good idea. T. Fricke said that including law enforcement is a stretch and she would like to see evidence of exposure risk to law enforcement. D. Gold said that the second reference in the summary sheet does address law enforcement in addition to corrections. J. Lincoln said he felt the sheet is beneficial.

Record keeping

B. Cotton asked, regarding page 21, (j)(1), where would the medical consultation be documented. Would they need to create a file on an exposure incident? D. Gold said that an employee's medical information would need to be kept in an employee's medical file, separate from the personnel file, as with bloodborne pathogens. She said that we needed more input on where employers should document exposure investigations. B. Cotton said that not all medical records are maintained in-house, some are kept by a third party. V. Wells noted that the medical records required by this standard would not be the same as pre-employment tests. Paul Fernandez noted that Napa has a medical provider for pre-employment evaluations. He asked if that provider could also provide vaccinations, and then that provider would maintain all the records. D. Gold said that the third party would need to be able to meet the access requirements, including providing the information in a

timely manner if there's an exposure incident. V. Wells said they keep records both in electronic and written form.

C. Camaddo-Nicolas asked if the standard requires respiratory protection for law enforcement and corrections. D. Gold said that it would depend on the employer's program. The intent is to require it for employers providing medical services for airborne infection isolation, but referring employers may also use respiratory protection. V. Wells asked if respiratory protection would be required if law enforcement officers were called in to deal with a known case. D. Gold said it would for an infectious case such as TB. She said it would also be required for law enforcement officers in a hospital, who would come under the requirements for hospitals.

Avian and Pandemic Influenza

D. Gold explained that if a pandemic flu strain develops, possibly from the avian influenzas currently circulating in parts of the world, then portions of this standard might be adopted as an emergency standard. She asked if people were dealing with pandemic flu. J. Lincoln responded that he is the safety officer in a four county exercise, although his role has yet to be defined. D. Gold said that one role for the safety officer in an exercise is to develop the safety plan. V. Wells said that in the exercise, it's really more of a security function. J. Fairbanks said that they had a desk top drill through their Office of Emergency Services that included the public health department and risk management. He is from Stanislaus County where they have a lot of poultry. D. Gold said that Cal/OSHA is trying to make sure that poultry workers and eradication workers are adequately protected. The Canadian experience with a high path poultry eradication effort showed that the N95 did not stand up well to the high work load and humidity. B. Cotton said that the firefighters had recommended using P-100's for pandemic flu. She asked if there is a good supply of them. D. Gold responded that there is not as much of a market for disposable P-100 filtering facepiece respirators as there is for N95's. The "P" means that it is oil resistant. Not everyone would agree with this recommendation. She said that P-100 cartridges are available and use in various industrial applications. V. Wells said that she had spoken to people at NIOSH, and they say there isn't an advantage in going to a 100 level filter vs. a 95 level filter to protect against virus containing particles.